EMPLOYER RESPONSE TO EMPLOYEE REQUEST FOR FAMILY OR MEDICAL LEAVE

(FAMILY AND MEDICAL LEAVE ACT OF 1993)

This form must be provided to an employee the first time in each six-month period that he/she gives verbal/written notice of the need for leave for an FMLA-qualifying reason. If information changes with respect to a subsequent period of FMLA leave during the six-month period, an updated form must be provided.

DATE: _____

TO: _____
(Employee's Name)

FROM: _____
(Name of Appropriate Agency Representative)

SUBJECT: Request for Family/Medical Leave

On _____, you notified us/we became aware of your need to take family/medical leave due to:
(Date)

☐ the birth of your child, or the placement of a child with you for adoption or foster care; or

☐ a serious health condition that makes you unable to perform the essential functions of your job; or

☐ a serious health condition affecting your ☐ spouse, ☐ child, ☐ parent, for which you are needed to provide care.

You notified us/we became aware that you need this leave beginning on _____ and that you expect
(Date)
leave to continue until on or about _____.
(Date)

Except as explained below, you have a right under the FMLA to receive up to 12 work weeks of leave during a "rolling" 12-month period measured backward from the date you use any FMLA leave for the reasons listed above. Also, your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work, and you must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from leave. However, you have no greater right to reinstatement or other benefits and conditions of employment than if you were continuously working during FMLA leave.

If you do not retire, or do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave (medical certification *may* be required); or (2) other circumstances beyond your control, you will be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave. This may include the following premiums paid while you were on unpaid leave: full premium for employee-only coverage; employee's portion of the premium for coverage through a health maintenance organization; and employee's portion of premium for dependent coverage.

This is to inform you that: (*check appropriate boxes; explain where indicated*)

1. You are ☐ eligible ☐ not eligible for leave under the FMLA.

2. The requested leave ☐ will ☐ will not be counted against your annual FMLA leave entitlement.

3. You ☐ will ☐ will not be required to furnish medical certification *(NPD-61)* of a serious health condition. If required, you must furnish the certification to _____ by _____
(Name) *(Date)*
(Employer must allow at least 15 calendar days) or commencement of your leave may be delayed until the certification is submitted.

4. You ☐ will ☐ will not be required to furnish recertification relating to a serious health condition. (*Note: Except in certain circumstances, cannot require more often than every 30 days or before duration of incapacity specified on initial certification has passed.*)

5(a). If appropriate for the purpose of the leave and authorized in accordance with federal regulations, you may elect to substitute accrued paid leave for unpaid FMLA leave or we may require that you substitute appropriate types of accrued paid leave.

5(b). We ☐ will ☐ will not require that you substitute appropriate types of paid leave for unpaid FMLA leave.

5(c). If paid leave will be used, the following conditions will apply: *(Specify the order and dates of leave time.)*

6(a). If you normally pay a portion of the premiums for your group health insurance (**e.g., premium for dependent coverage and/or for coverage through a health maintenance organization (HMO)**), these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments to _____ on the
(Appointing Authority or Designated Representative)
15th day of each month for insurance coverage for that calendar month.

6(b). You have a 30-day grace period in which to make payment. If payment has not been made during the grace period, your group health insurance may be canceled provided you are notified in writing at least 15 days before your health coverage will cease, or, at our option, we may pay your share of the premiums during unpaid FMLA leave, and recover these payments from you upon your return to work.

We: ☐ will pay your portion of the premiums for your group health insurance (e.g., premium for dependent coverage and/or for coverage through a HMO) while you are on unpaid leave and recover these payments from you when you return to work or, unless otherwise prohibited, when you terminate employment.

☐ will not pay your portion of the premiums for your group health insurance (e.g., premium for dependent coverage and/or for coverage through a HMO) while you are on unpaid leave. If your payment is not made during the grace period, your coverage will be cancelled retroactive to the last day of the month for which you paid the premium.

6(c). If you have optional insurance coverage which you normally pay through payroll deduction *(e.g., supplemental life insurance, cancer care insurance, etc.)*, you should make the premium payment directly to the Plan Administrator while you are on unpaid FMLA leave. The name and phone number of the Plan Administrator is available by contacting the Public Employees' Benefits Program at 684-7000. Any questions regarding continuation of coverage should be directed to the Plan Administrator. **We will not pay the premium for your optional insurance.**

7. You ☐ will ☐ will not be required to present a release to return to work prior to being restored to employment. If such certification is required but not received, your return to work may be delayed until such certification is provided. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on the reverse side of this form, you ☐ will ☐ will not be required to notify us at least two working days prior to the date you intend to report to work.

8. You ☐ will ☐ will not be required to furnish us with periodic reports of your status and intent to return to work every _____ weeks *(not more often than every 2 weeks)* while on FMLA leave.

9. While you are in unpaid leave status or on catastrophic leave, sick leave and annual leave will not accrue. The amount of time you are in unpaid leave status or catastrophic leave, in excess of 240 hours in a year may affect:

- your pay progression date
- the completion date of a probationary period
- longevity pay.

10. With respect to pension and other retirement plans, any period of unpaid FMLA shall not be considered a break in employment. However, service credit is not granted for any period of unpaid FMLA leave.

cc: Employee's Agency Confidential Medical File
Appointing Authority or Designated Representative